DCAP DEPENDENT CARE ASSISTANCE PROGRAM

DEPENDENT CARE REIMBURSEMENT CLAIM

STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

For questions, please call DCAP customer service at 360-664-7005 (in the Olympia area) or toll-free at 1-800-423-1524 and select option 4.

Please type or print in dark ink. Attach bill, receipt, invoice or complete Section Three Provider Information and return completed form to DRS.

Section One: Personal Information

Name _____ SSN _____

☐ Change Last First M.I.

Address _____ Work Phone _____

☐ Change Number Street

_____ Home Phone _____

City State Zip

Section Two: Expenses Incurred (See Reimbursement Claim Form Instructions)

Date of Birth	Dependent Name (Last, First, MI)	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Amount

Section Three: Provider Information (Required, if you are not submitting a bill, receipt or invoice)

Name _____

Address _____ City _____ State _____ Zip _____

I certify that I provided the dependent care services indicated on this form:

X _____ _____

Provider Signature Date

Section Four: Certification

- Each dependent listed above will qualify as a dependent on my federal income tax return for the current year. (If not, I have attached a statement of explanation.) These expenses are not for kindergarten or above.
- These expenses were necessary to allow me to work, and if married, to allow my spouse to work or to be a full-time student.
- My provider is not a dependent of mine and if my provider is a child of mine, that child will be at least age 19 as of the close of the current year.
- The expenses claimed above are eligible for reimbursement under the Dependent Care Assistance Salary Reduction Program and neither I, nor my spouse, nor my dependents have received reimbursement for these claimed expenses from this Dependent Care Program or another source.
- I understand any claim for which I am reimbursed cannot also be used for federal child and dependent care income tax credit purposes.

I hereby certify that all of the information I have entered on this form is true and complete:

Reset Form

X _____ _____

Signature of Employee Date

☐ Please send Reimbursement Forms

Please mail completed form to:
DEPARTMENT OF RETIREMENT SYSTEMS
DEPENDENT CARE ASSISTANCE PROGRAM
P.O. BOX 40931
OLYMPIA, WA 98504-0931

FOR DCAP USE ONLY

From	To	Approved Expenses

White - File Pink-Participant

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STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

P.O. Box 40931 • Olympia, WA 98504-0931 • 360-664-7005 • Toll-free 1-800-423-1524 • www.drs.wa.gov/dcap

Please use these instructions when completing the Reimbursement Claim form.

For questions regarding reimbursement, please call DCAP customer service in the Olympia area at (360) 664-7005 or toll free at 1-800-423-1524 and select option 4. You can also visit the DCAP Web site at: www.drs.wa.gov/dcap.

Section One: Personal Information

Type or print in dark ink. Please complete your personal information. Use your legal name and home mailing address.

Section Two: Expenses Incurred

For purposes of DCAP, the term "incurred expenses" means dependent care expenses for services that have already been provided. You may submit claims at any time. The DCAP system will reimburse you after the expense has been incurred.

To expedite reimbursement processing, monthly claims may be submitted for a shorter period of time.

Example:
You have a $500.00 claim for the month of August 2004:

Section Two: Expenses Incurred				
Date of Birth	**Dependent Name (Last, First, M.I.)**	**From (mm/dd/yyyy)**	**To (mm/dd/yyyy)**	**Amount**
10/15/1998	Smith, Betsy A.	8/1/2004	8/15/2004	$250.00
		8/16/2004	8/31/2004	$250.00

- On the first line, fill in the claim for the **first half** of the month.
- On the second line, fill in the claim for the **second half** of the month.

This will allow a portion of the claim to be processed on the first available pay date following the 15th rather than holding the entire claim until the end of the month.

Section Three: Provider Information

If you are not submitting a bill, receipt or invoice with your Reimbursement Claim form, the provider must complete this section. If you are submitting a bill, receipt or invoice without the provider's information, please include the provider's information at least once during the calendar year.

Section Four: Certification

If you have not completed Section Three, please attach bill, receipt or invoice and return completed form with your signature and date to:

Department of Retirement Systems
Dependent Care Assistance Program
P.O. Box 40931
Olympia, WA 98504-0931

Payments will be issued to you on the Tuesday after you submit eligible expenses approved for payment. In order to be reimbursed in the same week, you must have at least $25.00 in your account by Tuesday. Any unreimbursed portion of your claim will be paid from subsequent contributions, as your account balance allows.

Weekly Schedule

Monday - Reimbursement Claim form cut-off
Tuesday - Payments are issued
Wednesday - Payments are mailed
Holidays or unforeseen circumstances may vary the schedule slightly.